TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Charles Xeller, M.D.

Respondent Name
Harris County

MFDR Tracking Number
M4-23-0818-01

Carrier's Austin Representative
Box Number 21

DWC Date Received
December 7, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 29, 2022	Examination for Evaluation of Medical Care 99456-RE	$0.00	$0.00
	Administrative Fee 99199	$0.00	$0.00
	Range of Motion Testing 95851 x 2	$39.15	$35.25
	Total	$39.15	$35.25

Requestor's Position

THE CURRENT RULES ALLOW REIMBURSEMENT

Amount in Dispute: $39.15

Respondent's Position

Based on the submitted documentation and review of the bill history it has been found no additional payment is warranted at this time. The provider's dispute appears to be in relation to CPT code 95851 billed in the amount of $82.20. Payment was recommended in the amount of $39.15 which is in accordance with the TDI workers compensation current fee schedule.

Response Submitted by: IMO Managed Care

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the fee guidelines for professional medical services.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers compensation jurisdictional fee schedule adjustment.

Issues

1. Is Charles Xeller, M.D. entitled to additional reimbursement?

Findings

1. Dr. Xeller is seeking reimbursement for an examination for evaluation of medical care. Dr. Xeller is seeking $0.00 for procedure codes 99456-RE and 99199. Therefore, these codes will not be reviewed in this dispute. However, he is seeking $39.15 for range of motion testing. This code will be reviewed.

   Documentation submitted to DWC supports that Dr. Xeller performed range of motion testing for the lumbar spine and left upper extremity. Range of motion testing, represented by CPT code 95851, was billed at one unit for each body area. Therefore, Dr. Xeller is entitled to reimbursement of this service at two units as noted on the submitted billing.

   As stated in 28 TAC §134.203 (b) and (c), reimbursement for the services in question is based on Medicare policies using the conversion factor determined by DWC for the appropriate year. The conversion factor for 2022 is $62.46. Therefore, the MAR is $39.15 per unit for a total of $78.30. Harris County paid $43.05 according to the requestor. An additional reimbursement of $35.25 is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of $35.25 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Harris County must remit to Charles Xeller, M.D. $35.25 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 17, 2023
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.